Illinois Department of Public Aid

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INFORMATIONAL NOTICE

TO: Providers of Nursing Facility Services (ICF/SNF)

RE: LTC Provider Handbook Update - Bed Reserve

Effective August 1, 2004, the Department will begin reimbursing facilities, under the criteria listed below, to hold a bed while a resident is temporarily out of the facility for a hospitalization. This applies to bed reserves that began on August 1, 2004 or later.

The Department will now reimburse for up to 10 days per hospitalization while an individual is out of the facility if the facility has an occupancy level of at least 93% and at least 90% of the occupied beds are filled with Medicaid-eligible residents. The maximum reimbursable days for a therapeutic home visit will continue as seven consecutive or ten non-consecutive days per billing month, but the same two occupancy level calculations will also apply. Facilities holding a bed are reminded of the requirement to complete a Form DPA 2234, Bed Reserve/Temporary Absence Form, using the appropriate code listed in the attached handbook pages.

Bed reserves already submitted for time periods beginning August 1, 2004, or later must be resubmitted with the appropriate code by the facility if the occupancy requirements are met in order for payment to be made.

If you have any questions, contact the Bureau of Long Term Care at (217) 557-0602.

HANDBOOK REVISIONS

- Remove pages 41/42, 43/44, 84/85, 86, 253/254, 255/256, 257/258, 259/260, and 260(a) and replace with the attached pages.

C-230 COVERED SERVICES

The Medical Assistance Program provides payment for receipt of documented long term care facility services that are determined essential based on the attending physician's orders and the medical and/or social needs of the resident.

All participating long term care facilities are to provide the following services at no additional charge as they are recognized costs under the Department's cost-related reimbursement system:

= 1. All staff, routine equipment and supplies (including oxygen, if less than one tank has been furnished per resident during each service month) required to provide the services needed by residents accepted for care by a facility. (Examples of equipment and supplies to be provided include, but are not limited to: standard wheelchair, non-customized motorized wheelchair, walker, flotation pad and mattress, intermittent positive pressure machine, and those included in the program as "Personal Care Items" and listed in Appendix C-26). See Topic C-244 for policy regarding oxygen billing when one or more tanks per resident per month are used. See Topic C-243 for policy regarding therapy services;

2. Room and board, supervision and oversight, and all laundry services;

3. Food substitutes and nutritional supplements;

4. Medications which are regularly available without prescription at a commercial pharmacy and which may be stocked by the facility under Department of Public Health regulations, including, but not limited to, those listed in Appendix C-26;

5. Over-the-counter drugs or items ordered by a physician (including, but not limited to, drugs and items listed in the Department's Long Term Care Provider Handbook, Appendix C-26 and excluding drugs and items reimbursed under the Department's Drug Program); and

6. All other services necessary for compliance with the requirements of the Department of Public Health as set forth in Skilled Nursing and Intermediate Care Facilities Code, Rules and Regulations (77 Ill. Adm. Code, Section 300, Chapter I, Subchapter c)

=C-231 Reserve Bed

A facility may qualify to receive reimbursement at the rate of 75% of the Medicaid per diem rate for reserving a resident’s bed when the resident is temporarily absent from the facility. A facility must complete and submit to the Department, Form DPA 2234, Bed Reserve/Temporary Absence (see Appendix C-1)reporting the days that the resident is out of the facility, when the resident’s absence from the facility is due to hospitalization or a therapeutic home visit if the conditions specified below are met and documented.

= Effective August 1, 2004, the Department will reimburse facilities to hold a bed while a resident, while a resident is temporarily out of the facility for up to ten days per hospitalization. This policy replaces an earlier policy in place from July 1, 2003, through June 30, 2004, that ended reimbursement for bed reserve while a resident is hospitalized. To be reimbursed for a hospitalization, the facility must have an occupancy level of at least 93% and at least 90% of the occupied beds must be filled with Medicaid-eligible residents. The Department will continue to reimburse facilities while a resident is on a therapeutic home visit if the facility has an occupancy rate of at least 93%. At least 90% of the occupied beds must be filled by Medicaid-eligible residents. Maximum reimbursable days for a therapeutic home visit are seven consecutive or ten nonconsecutive days per billing month. A facility must report reserve bed days by submitting Form DPA 2234, Bed Reserve Form (See Appendix C-1) and reflect the days that the resident is out of the facility, when the resident's absence from the facility is due to hospitalization or a therapeutic home visit.

All payable bed reserves must be authorized by a physician.

In no facility may the number of vacant beds be less than the number of beds identified for residents being on bed reserve. The number of vacant beds in the facility must be equal to or greater than the number of residents allowed bed reserves.

The definitions and reserve bed codes to be used on Form DPA 2234 are:

10 - Payable Reserve Bed - Hospital Stay
11 - Nonpayable Reserve Bed - Hospital Stay
20 - Payable Reserve Bed - Therapeutic Home Visit
21 - Nonpayable Reserve Bed - Therapeutic Home Visit

The day the resident is discharged to the hospital is the first day of the ten day reserve period. The consecutive days related to hospital stays may cross billing periods.

= The NF must review the Prepayment Report and Remittance Advice to ensure residents are not incorrectly reported. Providers submitting through a REV/LTC-EDI vendor may correct bed reserves electronically within established bed reserve guidelines.

If the NF contests the days the hospital claimed for payment, it is recommended a Form DPA 2234, Bed Reserve Form be submitted for the day(s) in dispute with a DPA 3725 Payment Review Request along with all relevant documentation (nursing notes and midnight census report) that supports the NF's claim until a resolution can be reached.

The Bureau of Long Term Care will followup and take appropriate action on all conflicts with hospice and NF claims.

When a facility completes Form DPA 2234, Reserve Bed Request Form, for a resident on a therapeutic home visit, the first day of the reserve bed period is the first complete day the resident is out of the facility. If a resident is in the facility any part of the day, it is not counted as a reserve bed day; and the facility will receive the Medicaid authorized per diem rate.

When a resident is receiving hospice services and leaves the facility on bed reserve, it is not necessary to complete a Form DPA 2234. The Department's system has been updated to automatically generate bed type 41 for the long term care facility upon receipt of the payment request from the hospice provider.

In the event that bed type 41 is not reflected on the pre-payment report for dates for which a Medicaid client is receiving hospice services, contact the hospice agency providing the services. The Department will continue making payment to the long term care facility until the hospice provider bills and the bed type 41 is generated. Once the bed type 41 is generated, any payments made by the Department to the long term care facility for that period will be recouped. The long term care facility should contact the hospice agency providing the services if there are any questions regarding non-payment during the hospice stay.

C-231.1 Midnight Census Report

Each facility must compile a midnight census report daily. The information to be contained in the report includes:

- Total licensed capacity;
- Current number of residents in house at midnight each day inclusive of those in reserved bed status; and
- Name and disposition of residents not present in the facility, i.e. out on therapeutic home visit or hospitalization.

INSTRUCTIONS FOR COMPLETION AND SUBMITTAL OF FORM DPA 2234, LONG TERM CARE BED RESERVE FORM

= When a recipient is absent from the long term care facility and intends to return, the facility is responsible for completion and submittal of Form DPA 2234 as indicated in Section C-221 of this handbook.

The facility Administrator, or a designated agent with limited power of attorney, is to complete Form DPA 2234. Entries are to be typewritten or printed in black or dark blue ink. Leave the Document Control Number box blank.

Entries are to be made as follows:

FACILITY INFORMATION - COMPLETED BY FACILITY

. Enter - in the appropriate boxes - the 12 digit Facility I.D. Number, Facility Name, and Facility Address, exactly as they appear on the Provider Information Sheet.

. An entry in the Facility Reference Number box is not required, it is optional for the facility. Up to 10 numerical and/or alphabetical characters may be entered.

RECIPIENT INFORMATION - COMPLETED BY FACILITY

Enter the recipient's name (first name, last name) and nine digit Recipient I.D. Number exactly as they appear on the recipient's current Medical Eligibility Card. Do not use the Case Identification Number.

RESERVE BED INFORMATION - COMPLETED BY FACILITY

An entry is to be made in each of the three boxes on the same line (bed type, begin date, end date). Enter the bed type code and related dates of service in chronological date order. Use one line for each bed reserve period that consists of one day or two or more consecutive days.

Bed Type - Enter the correct two digit code to describe the recipient's stay status applicable to the dates entered on each line.

= 10 - (Payable Bed Reserve) - Hospital stay of up to 10 days per hospitalization if the facility has at least 93% occupancy and at least 90% of the occupied beds are filled with Medicaid-eligible residents.

11 - (Nonpayable Bed Reserve) - Hospital stay. The Nursing Home Care Act requires facilities to hold a bed for up to ten days per hospitalization. Facilities may choose to hold a bed longer than ten days. A completed Form DPA 2234 must reflect all the days the bed is held.

= 20 - (Payable Bed Reserve) - Therapeutic home visit of up to seven consecutive or ten days nonconsecutive days per billing month if the facility has at least 93% occupancy and at least 90% of the occupied beds are filled with Medicaid-eligible residents.

21 - (Nonpayable Bed Reserve) - Therapeutic home visit in excess of seven consecutive or ten days nonconsecutive days per billing month. Code 21 is also to be used when the recipient is temporarily absent from the facility due to a home visit, but the facility is unable, in accordance with policy, to claim a payable bed reserve visit.

When a resident is on hospice and leaves the facility on bed reserve, it is not necessary to complete a Form DPA 2234.

Begin Date - Enter the month, day and year for the first day of the reserve bed period using two digits for each entry; for example, July 13, 2003 is to be shown as 071303. For bed type 11, use the date of transfer to the hospital. For bed type 21 use the day following the date that the recipient left the facility. Note: The recipient must be absent from the facility for the entire day (midnight to midnight) in order for code 21 to be applicable.

End Date - Enter the month, day and year for the last day of the reserve bed using a six digit date as described above.

For bed type 11, the end date is the day before the date of return to the facility unless the absence is longer than ten days; then the tenth day is the end date.

EXAMPLE A - Recipient transfers to hospitals on July 1, 2003 and returns on July 4, 2003. The begin date is 070103, and the end date is 070303

EXAMPLE B - Recipient transfers to hospital July 1, 2003 and returns July 21, 2003. Begin date is 070103 and the end date is 072103 unless the facility decides to discharge the resident after the tenth day. In that case, the discharge date would be 701003.

For Bed Reserve Type 20. The end date is the day before the date of readmission up to and including the number of allowable days per stay (seven consecutive or ten days nonconsecutive per billing month if the facility has a occupancy level of at least 93%).

For Bed Reserve Type 21. The beginning date is the first day the resident has exceeded the allowable payable days or the day following the day of transfer if the facility is not eligible for payable bed reserve. The end date is the day before the date of readmission if the resident has exceeded the allowable payable days.

The NF must continue to review the Prepayment Report and Remittance Advice for accurate Bed Reserve information. If a conflict in dates appears and the NF contests the days the hospital claimed for payment, it is recommended a Bed Reserve Form DPA 2234 be submitted for the day(s)in dispute with a DPA 3725 Payment Review Request along with all relevant documentation (nursing notes and midnight census report) that supports payment to the NF until a resolution can be reached.

The Bureau of Long Term Care will followup and take appropriate action on all conflicts with **hospice** and NF claims.

A physician's letter is still required approving both hospitalization and therapeutic home visit bed reserve days.

When reporting a therapeutic home visit, the begin and end dates entered on Form DPA 2234 for reserve bed may not be prior to the first day or after the last day, respectively, of the billing period even though the recipient remained out of the facility beyond the last day of the billing period. Another Form DPA 2234 is required for the next billing period showing the begin date as the first day of the billing period.

Third Party Liability Credit Information has been removed from this form. Please refer to Form DPA 3461, Third Party Liability (TPL) Payment Transmittal (Appendix C-32) and instructions for the completion of this form (Appendix C-32a).

RESERVE BED CERTIFICATION STATEMENT - COMPLETED BY FACILITY

. The Administrator or designated agent is to sign and date the form to certify that all the information entered on the form is accurate and that the facility has met all requirements of the Department related to reserve bed days shown on the form. **If an employee as the Administrator's designated agent signs the form, the Administrator's name is to be signed followed by the employee's initials.**

SUBMITTAL INSTRUCTIONS

Submit the original to:

Illinois Department of Public Aid
Post Office Box 19108
Springfield, Illinois 62794-9108

"COMMONLY ASKED BED RESERVE QUESTIONS WITH ANSWERS"

NOTE: Policy and procedures regarding bed reserve are contained in Section C-231 of this handbook.

GENERAL PROCEDURES

1. Is there a difference between bed hold and bed reserve?

No.

2. Under what circumstances is a therapeutic home visit bed reserve approved?

When the facility provides documentation that the following criteria have been met:

= . physician statement that orders a home visit; and

= . the facility occupancy was at 93% or more of its bed capacity on the first day of the bed reserve period and at least 90% of the occupied beds are filled by Medicaid-eligible residents.

3. When a physician statement is received for a resident that is absent for a therapeutic home visit and then goes immediately to the hospital, do both absences qualify for bed reserve? (e.g., two day home visit, then ten day hospital or five day home visit, ten day hospital)

= Yes. In this situation, a physician statement for the hospitalization may be obtained after the fact (within 72 hours) since it was an emergency hospitalization. The hospital and therapeutic bed reserve are two distinct stays. The facility can bill for both at the maximum days allowed for each.

A hospitalized resident may also go directly from the hospital to a payable therapeutic home visit without returning to the facility as long as all other requirements are met.

4. Who is responsible for notifying the Department when Form DPA 3402, LTC Pre-payment Report, does not reflect accurate bed reserve information?

It is the responsibility of the facility to complete Form DPA 2234, Long Term Care Bed Reserve Form, and submit it to the Department. Send Form DPA 2234 to:

I.D.P.A.
Post Office Box 19108
Springfield, Illinois 62794-9108

5. Is Form DPA 1156, Long Term Care Facility Notification, required when Form DPA 2234, Long Term Care Bed Reserve Form, is submitted?

No. No other forms are required when submitting a Form DPA 2234.

6. Is Form DPA 1156, Long Term Care Facility Notification, required when Form DPA 2234, Long Term Care Bed Reserve Form, is submitted?

No. No other forms are required when submitting a Form DPA 2234.

GENERAL REQUIREMENTS

7. Does the Bureau of Long Term Care staff need to review nonpayable bed reserve stays?

= No. The Bureau of Long Term Care staff only needs to correct a type 10 or 20 (payable code) with a type 11 or 21 (nonpayable codes) on the bed reserve report when the facility has not met the required criteria.

8. Do the federal regulations require the State to make bed reserve payments?

No. Payment is optional under federal regulations. However, the Nursing Home Care Act requires that beds continue to be held ten days for hospitalizations regardless of whether or not the facility qualifies for payment.

9. Is there a limit to the number of residents that can be out of the facility on bed reserve at one time in order for the facility to still qualify for bed reserve payment?

No. As long as the requirements for payable bed reserve have been met and the facility has a vacant bed for each resident for whom bed reserve payment is being requested.

10. What will the Bureau of Long Term Care staff do if it is discovered there are not enough vacant beds to accommodate all the residents for whom bed reserve payments are being made?

If such discovery is made during the post payment review, further bed reserve payments will not be approved until there are enough vacant beds. Adjustments will be processed by the Department for all payments to which the facility is not entitled.

11. Must a facility close the chart when a resident is on bed reserve?

No. A resident's chart should only be closed when the resident has been discharged and has no intention of returning to the facility or has died.

12. Can the facility use either a preprinted physician statement or a stamp?

Yes. A preprinted physician statement may be used. However, the statement must have the physician's original signature.

HOSPITAL STAYS

=13. Is it possible to have more than one payable bed reserve period for hospitalization during the same billing period?

Yes. If the resident returned to the facility for a full day between hospital stays, the maximum of ten days may be used for each hospitalization. If a resident returns to the facility, then is readmitted to the hospital the same day, the ten day bed reserve used for the initial hospitalization continues.

=14. Does the Department ever grant extensions on the ten day bed reserve payment for hospitalizations?

No.

=15. Can the family voluntarily make bed reserve payments on behalf of a resident who remains hospitalized beyond ten days?

Yes.

16. Does the physician's statement have to be signed on the same day the resident is transferred to the hospital?

No. Transfers are permitted based on telephone orders. The physician's signature must be obtained within 72 hours of the transfer.

=17. Can a facility receive bed reserve payment for a resident that is on Medicare upon admission to the hospital?

Yes. The facility can receive bed reserve bed reserve payment as long as all other criteria for payable bed reserve are met. The facility will be reimbursed at 75% of the Medicaid rate.

=18. If the resident dies in the hospital during the ten day bed reserve period, is the facility paid for the day of death?

Yes. The facility will receive payment if the resident is on a payable bed reserve.

19. When a resident leaves the facility for a hospitalization, what day does the bed reserve period begin?

The bed reserve begins the day the resident is hospitalized. For therapeutic visits, see question #25.

=20. Can bed reserve payments for hospital stays overlap billing months?

Yes. However, the payment is limited to ten days per hospital stay. If a hospital stay overlaps a month, when completing Form 2234, use the last day of the month as the End Date. The next month’s overlapping bed reserve period must be entered on a separate line.

THERAPEUTIC VISITS

21. Does there have to be a separate physician statement for each therapeutic home visit?

There must be a physician statement for each individual resident, but not for each visit the resident makes. The physician must review the order every six months.

22. What are the occasions that require prior approval, Bed Type 30, Extended Home Visit?

Extended home visits such as holidays, vacations or any home visit that may exceed the maximum days allowed. Refer to Section C-231, Reserve Bed, for further information.

23. Can bed reserve payments for therapeutic home visits overlap billing months?

No. Payment is restricted to seven consecutive or ten nonconsecutive days each billing month.

24. Is there a limit to the number of therapeutic payable bed reserve days per year?

No. The seven consecutive days or ten nonconsecutive days may be used per billing month. Therapeutic home visits can be extended with prior approval.

25. When a resident leaves a facility for a therapeutic home visit, what day does the bed reserve period begin?

Payment for bed reserve begins the day after the resident leaves the facility for the therapeutic home visit.

26. If a resident leaves a facility for a therapeutic home visit one day and returns to the facility the following day, is there a bed reserve payment?

No. Bed reserve is not paid for the day a resident leaves the facility for a therapeutic home visit, payment would begin on the following day. Since the resident returned to the facility the following day, the full per diem would be paid for that day.

OCCUPANCY LEVEL

=27. Are private pay residents included in the required 93% occupancy?

Yes. However, effective August 1, 2004, the additional requirement of at least 90% of the occupied beds being filled by Medicaid-eligible residents must be met for a bed reserve to be payable. This is required for both hospitalizations and therapeutic home visits.

=28. How is the 93% occupancy calculated for facilities without a distinct part? (Distinct part facilities see Questions #29 and 30)

The occupancy rate is calculated by dividing the number of occupied beds by licensed capacity. Include both payable and nonpayable beds (nonpayable defined as those residents that are hospitalized or have transitioned from the maximum days allowed for payable bed reserve to a nonpayable bed reserve status–seven consecutive days or ten nonconsecutive days per billing month for therapeutic stay) in the number of occupied beds.

Following are examples of the 93% occupancy calculation.

EXAMPLE 1
Licensed 125
Occupancy ÷ 117 (115 in NF + 2 on last day of Type 10 bed reserve)
117 ÷ 125 = 93.6%

EXAMPLE 2

Licensed 125
Occupancy 117 (115 in NF + 2 in transition to Type 11 bed reserve)
117 ÷ 125 = 93.6%

=29. How is the 93% occupancy calculated for facilities that entered the Medicaid Program as a distinct part?

The occupancy rate is calculated by dividing the number of occupied beds by Medicaid-certified capacity. Include both payable and nonpayable beds (nonpayable defined as those residents that are hospitalized or have transitioned from the maximum days allowed for payable bed reserve to a nonpayable bed reserve status–seven consecutive days or ten nonconsecutive days per billing month for therapeutic stay) in the number of occupied beds.

Distinct Part
Certified (Distinct Part) 20
Occupancy (Distinct Part) 19
19 ÷ 20 = 95%

=30. How is the 93% occupancy calculated for facilities that reduced its number of Medicaid-certified beds to become a distinct part?

For a facility that has reduced its number of Medicaid-certified beds there are two separate calculations.

To determine the occupancy for bed reserve for Medicaid eligible residents who reside outside of the distinct part, use the number of occupied beds in the entire facility, including beds located in the distinct part, divided by the number of licensed beds.

To determine the occupancy for bed reserve for Medicaid eligible residents who reside in the distinct part, use only the number of occupied beds in the distinct part, divided by the number of licensed beds.

=31. How is the 90% Medicaid occupancy calculated?

The percentage of Medicaid occupied beds is calculated by dividing the number of Medicaid residents by occupied beds. Include in the occupied number those currently occupied beds and those in payable and nonpayable bed reserve status (nonpayable defined as those residents that are hospitalized or have transitioned from the maximum days allowed for payable bed reserve to a nonpayable bed reserve status–seven consecutive days or ten nonconsecutive days per billing month for therapeutic stay).

=32. Are percentages rounded off when calculating the 93% and 90% occupancy levels for determining payable bed reserve?

Yes. If the occupancy level calculated is 92.4% or less, the facility is not eligible for bed reserve payment. Occupancy levels at 92.5% or higher would qualify the facility for bed reserve payment if the Medicaid occupancy of those 93% occupied beds is at least 90%.

If the Medicaid occupancy level calculated is 89.4% or less, the facility is not eligible for bed reserve payment. Medicaid occupancy levels at 89.5% or higher would qualify the facility for bed reserve payment.

33. Are beds not set up included in the licensed capacity?

Yes. The total number of licensed beds is considered regardless of whether or not the facility actually has that number of beds set up. The licensed capacity can be changed by contacting the Department of Public Health.

34. Are shelter care beds included in the licensed capacity?

No. Shelter care beds are not included in the licensed capacity and will not be used in calculating bed reserve.

35. Will the Bureau of Long Term Care staff include private pay beds being held by the facility when calculating the 93%?

Yes. It is the facility's responsibility to provide verification.

37. The facility is not at 93% occupancy level on the first day of a bed reserve. Can the facility claim bed reserve if a 93% occupancy level is reached at any time during the bed reserve period?

No. The occupancy level calculated on the first day of the bed reserve period is used throughout that bed reserve period.

38. If a resident is occupying a room with two beds and the resident is paying for both, is the unoccupied bed included in the daily census when calculating reserve beds?

Yes. This would be considered an occupied bed since it cannot be used by another resident.

39. Will vacant Medicare beds be included in the census when calculating bed reserve?

Vacant Medicare beds will be included in the census only if the beds are dually certified as Medicaid/Medicare. Beds certified as a Medicare distinct part are not to be included in calculating bed reserve. For example, if the facility is licensed for 135 beds and 25 of those are licensed as Medicare only, 110 beds would be included in the calculation for bed reserve.

=40. What is the midnight census and how is it used to calculate occupancy?

The midnight census is the last patient census of the day. The number of beds occupied at the midnight census is used to determine if the 93% occupancy rate required for payment of bed reserve has been met. Of those residents listed on the midnight census, at least 90% must be Medicaid-eligible for a bed reserve to be paid. When a resident is on a hospitalization, the facility shall consider the midnight census on the day of transfer when determining eligibility for bed reserve. When a resident is on a therapeutic home visit, the facility shall consider the midnight census on the day following the day of transfer when determining eligibility for bed reserve. Additionally, the resident being transferred would not be included in the census taken at the end of the day following the day of the transfer. However, if the facility qualified for paid bed reserve, the resident would be included in the midnight census taken on the following days.

Hospitalization

Mrs. Jones was hospitalized on July 10. The midnight census for that day would not show her in the facility. If the unoccupied bed did not drop the occupancy rate below 93% with 90% of those occupied beds being filled by Medicaid-eligible residents, Mrs. Jones hospitalization will be payable.

Therapeutic Home Visit

Mrs. Jones left the facility on a therapeutic home visit on July 10. The midnight census for that day would show her in the facility. The midnight census on July 11 would show her not in the facility. If the unoccupied bed did not drop the occupancy rate below 93% with 90% of those occupied beds being filled by Medicaid-eligible residents on July 11 midnight census, Mrs. Jones home visit will be payable bed reserve period.

=41. When calculating the 93% occupancy level for bed reserve payment in facilities that are dually certified, (SNF/ICF and ICF/MR), are all licensed beds included in calculating the 93% occupancy level, or only the licensed beds for each applicable level of care?

Only the licensed beds for skilled and intermediate care will be considered when calculating the 93% occupancy level and the 90% Medicaid occupancy level for payable bed reserve.

PAYMENT

=42. What is the first day of payment at 75% of the per diem?

For hospitalizations, it is the day of transfer. For therapeutic home visits, it is the day after the day of transfer.

43. What is the last day of payment at 75% of the per diem?

The last day of payment at 75% of the per diem is the day before readmission. For residents who die or are discharged while on payable bed reserve, the Department will pay 75% of the per diem for the day of death or discharge.

44. Does the Department pay 75% or the total per diem on the day of readmission?

The Department always pays the full per diem on the day of readmission.

=45. Would the Department pay 75% or the full per diem for a day in which a resident is admitted to and discharged from a hospital on the same day?

The Department would pay the full per diem as long as the hospital admission and discharge dates were the same.

=46. How is Medicaid-eligible defined?

A Medicaid-eligible resident is one who has been assigned a Recipient Identification Number (RIN).

DISCHARGE

47. How long can a Bed Type 11 be carried without discharging the resident?

There is no time limit on the number of days for which a facility may reserve the nonpayable bed, as long as a vacant bed remains available.

48. Can a facility claim bed reserve when a resident is transferred to a state-operated facility?

No. State-operated facilities are also long term care facilities. Residents admitted to state-operated facilities must be discharged from the facility they were in previously.

49. When the resident is hospitalized for less than ten days, is he to be discharged from the nursing home?

No. Pursuant to the 77 Il Admin. Code 3300.300 and 89 Il Admin. Code, 140.700, the individual is considered a resident of the facility for at least ten days and until discharge proceedings are completed.

50. Is the facility allowed to discharge residents or refuse readmission when they exceed the maximum allowable bed reserve?

No. The facility must follow the procedure for involuntary discharge as defined in 77 Il Admin. Code 3300.300.

51. If a resident leaves a facility on payable bed reserve and later notifies the facility they are not returning, is the facility eligible to receive a bed reserve payment?

Yes. When a resident notifies the facility of his or her intent not to return to the facility during the temporary absence, the facility would be entitled to bed reserve up to the date of notification by the resident (since the facility showed good faith in holding the bed). The facility would complete Form DPA 1156 to report the discharge by using the date of notification as date of discharge.